2023 LHD Assessment of Health Care Transition (HCT) Activities

The State of Michigan Children's Special Health Care Services (CSHCS) program is conducting a survey to be completed by each Local Health Department (LHD) regarding their Transition to Adulthood activities and the implementation of the Six Core Elements of Health Care Transition (HCT). The results of this 2023 survey assessment will provide your LHD with data related to current activities and will be compared with your 2022 survey responses. This comparison will show changes over time and assist your LHD in identifying areas in which more comprehensive activities can be implemented.

The following HCT assessment has been adapted from the Got Transition's Current Assessment of Health Care Activities. The Six Core Elements of Health Care Transition™ are the copyright of Got Transition®. This version of the Six Core Elements has been modified and is used with permission.

Please complete the assessment of HCT activities for each of the Six Core Elements by selecting the level that best describes your LHD activities - between 1 (basic) and 4 (comprehensive). If the level is partially, but not fully applicable, please select the lower level.

It is recommended to discuss and complete this assessment with your CSHCS care coordination team.

Q1. Please select the level that would best describe your LHD's CSHCS Transition Policy.

- *Level 1.* Care coordinators follow a similar approach to HCT but do not have a written policy.
- *Level 2.* The care coordination program has a written HCT policy that describes its HCT approach, legal changes that take place in privacy and consent at the age of 18, and the age when Title V eligibility ends.
- *Level 3.* The care coordination program has a written HCT policy that describes its HCT approach, legal changes that take place in privacy and consent at the age of 18, and the age when Title V eligibility ends. Care coordinators consistently discuss HCT with all YSHCN and their families, beginning at ages 12 to 14.
- *Level 4:* The care coordination program has a written HCT policy that describes its HCT approach, legal changes that take place in privacy and consent at the age of 18, and the age when Title V eligibility ends. Care coordinators consistently discuss HCT with all YSHCN and their families, beginning at ages 12 to 14. The transition policy also describes the facilitation of additional transition to adulthood domains including work and independence.

(Note: Having a Transition policy is included in indicator 6.3 of the CSHCS Minimum Program Requirements. Options for discussing HCT with YSHCN and their families may include POC visits, over the telephone, or mailing a letter/transition packet. The topic of HCT should be introduced to the client and their families prior to the age of 14. Between the ages of 14-15, LHD staff should encourage the completion of a HCT readiness/self-care skill assessment tool, so the client has time to begin learning the skills needed to be as independent as possible as an adult.)

Q2. Please select the level that would best describe your LHD's CSHCS HCT Tracking and Monitoring.

- *Level 1.* Care coordinators vary in the identification of transition-aged YSHCN, but most wait until close to the age of transfer to prepare youth for HCT.
- *Level 2.* Care coordinators use client records to document relevant HCT information (ex: discussed transition, date of transfer to adult doctor)
- *Level 3.* The care coordination program uses an individual transition tracking system for identifying and tracking a subset of transition-age YSHCN, ages 14 and older, as they complete some but not all the Six Core Elements of HCT.
- *Level 4.* The care coordination program uses an individual transition tracking system for identifying and tracking all transition-aged YSHCN, ages 14 and older as they complete all of the Six Core Elements of HCT.

Q3. Please select the level that would best describe your LHD's CSHCS Transition Readiness assessment tools used in identifying the needs of YSHCN and their families.

- *Level 1.* Care coordinators vary in whether they assess HCT readiness/self-care skills.

- *Level 2.* Care coordinators assess HCT readiness/self-care skills but do not consistently use a HCT readiness assessment tool.
- *Level 3.* Care coordinators assess HCT readiness/self-care skills using a HCT readiness/self-care skill assessment tool.
- *Level 4:* Care coordinators consistently assess and re-assess each year HCT readiness/self-care skills, starting at ages 14 to 15, using a transition readiness/self-care assessment tool.

(Note: The topic of HCT should be introduced to the client and their families prior to the age of 14. Between the ages of 14-15, LHD staff should encourage the completion of a HCT readiness/self-care skill assessment tool, so the client has time to begin learning the skills needed to be as independent as possible as an adult.)

Q4. Please select the level that would best describe your LHD's CSHCS Transition Planning.

- *Level 1.* Care coordinators vary in whether they include goals and action steps related to HCT in the plan of care for YSHCN.
- *Level 2.* Care coordinators consistently include goals and action steps related to HCT for YSHCN but vary in addressing privacy and consent changes that take place at age 18 and, if needed, decision-making supports for adult-focused healthcare.
- *Level 3.* Care coordinators consistently include goals and action steps related to HCT for YSHCN based on the results from a HCT readiness assessment tool. Care Coordinators consistently address privacy and consent changes that take place at age 18 and, if needed, decision-making supports for adult-focused health care. The plan of care is regularly updated.
- *Level 4.* The care coordinator program has incorporated HCT into its plan of care template for all YSHCN. Care coordinators consistently include goals and action steps related to HCT for YSHCN based on the results from a HCT readiness assessment tool. Care coordinators consistently address privacy and consent changes that take place at age 18 and, if needed, decision-making supports for adult-focused health care. The plan of care is regularly updated and shared with YSHCN and families.

(Note: Regularly updating the POC would be based on your LHD's policy. CSHCS Guidance Manual for LHD's states a Level 1 POC can be developed for a client once within an eligibility year and POC revisions within that same timeframe could be billed as a Level 2.)

Q5. Please select the level that would best describe your LHD's activities related to Transfer of Care to adult providers for CSHCS clients.

- *Level 1.* Care coordinators vary in whether they provide YSHCN and families with resources to find adult providers. They rarely share plans of care with HCT information to adult providers for their transitioning YSHCN.
- *Level 2.* Care coordinators consistently provide YSHCN and families with resources to find adult providers and share plans of care with HCT information to adult providers for their transitioning YSHCN. Care coordinators vary in whether they include goals and action steps related to transfer of care to adult providers in the plan of care for YSHCN.
- *Level 3.* Care coordinators consistently provide YSHCN and families with resources to find adult providers and share plans of care with HCT information to adult providers for their transitioning YSHCN. Care coordinators include goals and action steps related to transfer of care to adult providers in the plan of care for YSHCN.
- *Level 4.* Care coordinators consistently provide YSHCN and families with resources to find adult providers and share the plan of care with HCT information to adult providers for their transitioning YSHCN. Care coordinators include goals and action steps related to transfer of care to adult providers in the plan of care for YSHCN. In addition, care coordinators routinely communicate with the youth or family that transfer of care to adult providers was completed.

(Note: Providing resources to find adult providers may include providing a physician referral line, encouraging the client/family to work with their pediatric provider for a referral, contacting the primary insurance for a list of participating providers, etc. These resources could be provided during a POC visit, telephone call or included in the transition packet.)

Q6. Please select the level that would best describe your LHD's activities regarding HCT program evaluations for CSHCS clients that are of Transition Completion age.

- *Level 1.* Care coordinators vary in whether they follow-up with YSHCN and parents/caregivers about the HCT support provided by the care coordinator program.
- *Level 2.* Care coordinators consistently encourage YSHCN and parents/caregivers to provide feedback about the HCT support provided by the care coordination program, but do not use a specific HCT feedback survey.
- *Level 3.* Care coordinators consistently obtain feedback from YSHCN and parents/caregivers using a HCT feedback survey.
- *Level 4.* Care coordinators consistently obtain feedback from YSHCN and parents/caregivers using a HCT feedback survey and use the results as part of its transition performance measurement for the Title V block grant reporting.

(Note: Having family input regarding the local CSHCS program annually is included in indicator 3.3 of the CSHCS Minimum Program Requirements. Options for program evaluations may include adding HCT questions to an existing survey or creating a separate HCT survey for clients aging out of the program.)

Q7. Please select the LHD name and county for which you are completing this survey (drop down menu inserted).

Q8. Please share any suggestions or challenges that your LHD may have regarding CSHCS transition policies, documents, and trainings.

Thank you for participating in our survey. Your feedback is important to us.